Appendix 11

Sample Completed Prior Authorization Durable Medical Equipment Attachment (PA/DMEA)

Mail To:
Wisconsin Medicaid
Prior Authorization Unit
Suite 88
6406 Bridge Rd.
Madison, WI 53784-0088

PA/DMEA

PRIOR AUTHORIZATION DURABLE MEDICAL EQUIPMENT ATTACHMENT

1. Complete this form.
2. Attach to PA/RF.
   (Prior Authorization/Request Form)
3. Mail to Wisconsin Medicaid.

RECIPIENT INFORMATION

(1)	(2)	(3)	(4)	(5)
Recipient	Im	A	1234567890	35
LAST NAME	FIRST NAME	MIDDLE INITIAL	MEDICAL ASSISTANCE ID NUMBER	AGE

PROVIDER INFORMATION

(6)	(7)	(8)
I.M. Prescribing	12345678	(XXX) XXX-XXXX
PRESCRIBING PHYSICIAN'S NAME	PRESCRIBING PHYSICIAN'S MEDICAL ASSISTANCE PROVIDER NUMBER	DISPENSING PROVIDER'S TELEPHONE NUMBER

A. Describe the overall physical status of the recipient: (mobility, self-care, strength, coordination)

Is independent in mobility and self cares. Shows adequate and normal strength and coordination.

B. Describe the medical condition of the recipient as it relates to the equipment/item requested — Why does the recipient need this equipment?

Has Type 1 diabetes, was recently in good control with BID testing of blood sugars. Recent bladder infection, currently on antibiotics. Physician ordered additional testing. Increased to 5x's per day.

C. Is the recipient able to operate the equipment/item requested — ☒ Yes ❑ No — if not, who will do this?

Independent

D. Is training provided or required? ❑ Yes ☒ No Explain: **Recipient previously instructed on proper glucometer use. Demonstrates good technique.**

E. State where equipment/item will be used:

☒ Home (Describe type of dwelling and accessibility)

Ranch type, NO accessibility problems.

❑ Nursing Home ❑ School ❑ Office ❑ Job
(Describe type of dwelling and accessibility)

F. Attach an Occupational or Physical Therapy Report if available.
Not applicable.

G. State estimated duration of need:
2-3 months. Once infection resolved will decrease to BID testing.

H. If renewal or continuation of DME Authorization is requested, describe the recipient's
- Current clinical condition
- Progress (improvement; no change, etc.)
- Results
- Recipient's use of equipment/item prescribed

Initial PA request, not applicable.

I. Indicate amount of oxygen to be administered: **Not applicable.**

____ Liters per minute	____ Continuous
____ Hours per day	____ PRN
____ Days per week	____ PaO_2

Attach a photocopy of the Physician's Prescription to this Attachment form. The prescription must be signed and dated within 6 months of receipt by Wisconsin Medicaid.

THE PROVISION OF SERVICES WHICH ARE GREATER THAN OR SIGNIFICANTLY DIFFERENT FROM THOSE AUTHORIZED MAY RESULT IN NON-PAYMENT OF THE BILLING CLAIM(S).

J. **MM/DD/YYYY** I.M. Provider

Date — Requesting Provider's Signature